LIFE/DISABILITY ENROLLMENT FORM

THE HARTFORD

☐ Initial ☐ Change ☐ Termination ☐ Reinstatement

TO BE COMPLETED BY THE EMPLOYEE

NAME LAST	FIRST	M. I.	BIRTH DATE: M/D/Y

SOCIAL SECURITY NUMBER	SEX	MARITAL STATUS	DATE OF MARRIAGE: M/D/Y
	☐ M ☐ F	☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced	

EMPLOYEE HOME ADDRESS STREET CITY STATE ZIP

DEPENDENT INFORMATION (*Complete only if dependent coverage is available and elected.*) [DEP LIFE ONLY] LAST FIRST M. I.	SEX: M/F	BIRTH DATE: M/D/Y
SPOUSE (***Indicate last name if different than Employee***) N/A		
CHILD N/A		
CHILD		
CHILD		

Indicate type of coverage below. You may only elect coverages reflected in your Employer's contract. (*You will not be covered for coverages not included in your Employer's contract.)* To elect coverage check the box marked "Y". To decline coverage check the box marked "N".

BASIC LIFE	SUPP LIFE	AD/D	WEEKLY DISABILITY	LTD
☒ Y ☐ N AMT $50,000.00	☐ Y ☒ N ☐ _____ x Basic Annual Earnings ☐ OTHER	☒ Y ☐ N	☐ Y ☒ N ☐ FLAT AMT_____	☐ Y ☒ N

DEPENDENT LIFE	SUPP AD/D	LTD BUY-UP
SPOUSE ☐ Y ☒ N AMT _____ CHILD ☐ Y ☒ N AMT _____	☐ Y ☒ N	OPTION 1 N/A % OPTION 2 _____%

BENEFICIARY DESIGNATION—Please refer to the reverse side of this form for important information regarding beneficiary designation.

FULL NAME ADDRESS SSN RELATIONSHIP D.O.B.

PRIMARY

CONTINGENT

☐ I hereby apply for the coverages I have indicated above on behalf of myself and all dependents listed, and I authorize my Employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between Hartford Life and my Group Plan.

☐ I hereby waive the coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability, that is satisfactory to Hartford Life, before my coverage will become effective.

Signature _____ **Date** _____

TO BE COMPLETED BY THE EMPLOYER

POLICY SYMBOL	POLICY NUMBER	BILL UNIT	LOSS UNIT	BUSINESS LOCATION STATE	ORIGINAL EFFECTIVE DATE OF POLICY
	873977				

EMPLOYER NAME	EMPLOYEE HIRE DATE	EFFECTIVE DATE OF COVERAGE
RIO HONDO COLLEGE		

EMPLOYEE OCCUPATION	EMPLOYEE CLASS	LIFE	WD	LTD

SALARY $ _____ ☐ Annual ☐ Monthly ☐ Weekly ☐ Hourly

TERMINATION DATE	REINSTATEMENT DATE

For Policyholders covered under Pennsylvania Long Term Disability policies: If, within 90 days immediately prior to becoming covered under the group contract, you or any dependent have received medical care or advice for a disease or physical condition, you, he or she may not be covered for such disease or physical condition until you, he or she has been covered for one year under this contract. This exclusion, however, only applies to a disease or physical condition for which medical care or advice has been received within 90 days immediately prior to becoming covered under the group contract..

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